MISSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

PARTMENT OF PUBLIC HEALTH AND WELFARE

-62-001228
STATE FILE NUMBER

AMENDED

Registration District No. 129 Primary Registration District No. 2100 Registrar's No. 113

FILED JAN 29 1962

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO. | SHOULD READ | INSTEAD OF | DATE AMENDED | BY AFFIDAVIT OF | DOCUMENT

1. PLACE OF DEATH
a. COUNTY GREENE
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN SPRINGFIELD
Length of stay in 1b 20 DAYS
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION BAPTIST HOSPITAL
Inside Limits Yes [X] No [ ]

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MO b. COUNTY WEBSTER
c. CITY OR TOWN MARSHFIELD
Inside Limits Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location) 203 N. PINE
Reside on Farm Yes [ ] No [X]

3. NAME OF DECEASED (Type or print) First EDWARD Middle JOSEPH Last RADER
4. DATE OF DEATH Month JAN Day 19 Year 1962
5. SEX MALE
6. COLOR OR RACE WHITE
7. Married [X] Never Married [ ] Widowed [ ] Divorced [ ]
8. DATE OF BIRTH 3-21-1883
9. AGE (Last birthday) 78
IF UNDER 1 YEAR Months Days IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RET FARMER
10b. KIND OF BUSINESS OR INDUSTRY —
11. BIRTHPLACE (City and state or country) MISSOURI
12. CITIZEN OF WHAT COUNTRY U.S.A
13a. FATHER'S NAME SIMEON RADER
13b. MOTHER'S MAIDEN NAME MARTHA CAFFEY
14. NAME OF HUSBAND OR WIFE MYRTLE
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of servic
16. SOCIAL SECURITY NO.
17. INFORMANT MYRTLE RADER Address MARSHFIELD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Thrombosis
INTERVAL BETWEEN ONSET AND DEATH 48 hrs
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b)
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Benign Hypertrophy of Prostate
PART III. If deceased was female was there a pregnancy in last 90 days. [ ] Yes [ ] No [ ] Unknown

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]
20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ]
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from 1-9-62, to 1-19-62 and last saw her/him alive on 1-19-62
Death occurred at 11:07 Am on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE William F. Johnson (Degree or title) M.D.
22b. ADDRESS 211 prof. Bldg., Springfield, Mo
22c. DATE SIGNED 1-22-62

23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL
23b. DATE 1-19-1962
23c. NAME OF CEMETERY OR CREMATORY MARSHFIELD
23d. LOCATION (City, town, or county) MARSHFIELD (State) MO
24. FUNERAL DIRECTOR ADDRESS BARBER-EDWARDS. MARSHFIELD
25. DATE RECD. BY LOCAL REG. 1-23-62
26. REGISTRAR'S SIGNATURE Effie B. Melton

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____, Student Embalmer No._____ working under my personal supervision.

Student_____
Signature of Student Embalmer

Signed R W Boyle

Licensed Embalmer No. 384

P. O. Address Glen Grove Tx

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.